RS-3j (rev. 7/1/12)

Virginia Department for Aging and Rehabilitative Services
Division of Rehabilitative Services

Authorization to Release Drug and Alcohol Diagnosis and Treatment Records

Return the requested information to *(Name & address)*:

FAX:

Client Birth Date _____ Participant ID or SSN *(Optional)* _____

I, *(Print client full name)* _____

Of *(Address)* _____

authorize *(Custodian of information)* _____ (or successor)

to disclose the following information *(Specify):*

_____

This authorization includes information placed in my records after the Signature Date: Yes ☐ No ☐

to *(Name or job title or entity)* _____ (or successor)

for the following purpose(s): _____

I understand that my records are protected under federal and state confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise allowed or required by law or regulation. I understand that even if I am under the age of 18, my parent/guardian(s) may not be able to review certain outpatient drug or alcohol treatment records without my expressed written consent. I further acknowledge that the information to be released was fully explained to me and that this consent is given of my own free will.

A disclosure may not be made on the basis of an authorization which 1) has expired, 2) on its face is substantially deficient, 3) is known to have been revoked, or 4) is known, or through a reasonable effort could be known, by the person holding the records to be materially false.

I understand that I have the right to revoke this authorization by writing to the Custodian of Information at the address listed above. This authorization is subject to revocation at any time except to the extent that the program/entity which is to make the disclosure has already taken action in reliance on this form. **This authorization shall expire one year from the Signature Date or on the date, event or condition specified: _____ , whichever occurs first.**

Client Signature _____ Date _____

Parent/Guardian *(If required)* _____ Sign _____

Person authorized to sign for client, if required: *(Print name)* _____

Signature _____ Date _____

Provide a copy to the client

NOTE WHERE INFORMATION ACCOMPANIES THIS DISCLOSURE FORM. This information has been disclosed to you from records protected by the Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.